



**TEXAS INSTITUTE OF CARDIOLOGY, P.A.**  
**FAISAL WAHID, M.D., F.A.C.C., F.S.C.A.I**

4510 MEDICAL CENTER DR. SUITE 208  
MCKINNEY, TEXAS 75092

**Authorization to Release Health Care Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Previous Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I request and authorize **Texas Institute of Cardiology, P.A.** to release health care information of the patient named above to:

Name: \_\_\_\_\_  
Addresses: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Copies of the complete history records in your possession concerning my illness and/or treatment to include:

EKGs       All Lab Work       All Cardiac Procedures  
Purpose of Disclosure:       Medical Center       Employer       Insurance       Attorney  
 Other: \_\_\_\_\_

We will not disclose your Medical information for any purpose except for treatment, payment and healthcare operations. Any specific written authorization you provide may be revoked at any time by writing us. I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name if Individual is not Patient

\_\_\_\_\_  
Relationship to Patient

Phone: 214-544-7555 / 866-391-4311

Fax: 214-544-7556

[www.ticardiology.com](http://www.ticardiology.com)

[info@ticardiology](mailto:info@ticardiology)



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